No.

IN THE

Supreme Court of the United States

OCTOBER TERM, 1997

BONNIE L. GEISSAL
as representative of the
Estate of JAMES W. GEISSAL, deceased,
Petitioner,

v.

MOORE MEDICAL CORP.,
GROUP BENEFIT PLAN OF MOORE MEDICAL CORP.,
and HERBERT WALKER,
Respondents.

Petition for a Writ of Certiorari to the
United States Court of Appeals for the Eighth Circuit

PETITION FOR WRIT OF CERTIORARI

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54 pp

QUESTION PRESENTED

I. Under the Consolidated Omnibus Budget Reconciliation Act (COBRA), which provides that health insurance coverage may not be suspended until the worker ("qualified beneficiary") first becomes, after the date of the election, covered under any other group health plan, 29 U.S.C. §1162(2)(D)(i), does preexisting spousal/domestic partner health insurance coverage disqualify the beneficiary from his own right to COBRA continuation coverage?

II. If preexisting spousal/domestic partner health insurance coverage does disqualify a worker from his own right to continue at his expense health insurance coverage under COBRA except when the preexisting coverage is somehow insufficient ("gap"), what is the nature of such "gap," how should such "gap" be measured, and who bears the burden of going forward and proof on such "gap" issue, the worker, the employer, the benefit plan or the health insurer?

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PETITION FOR WRIT OF CERTIORARI

Plaintiff respectfully prays that a writ of certiorari issue to review the judgment and opinion of the United States Court of Appeals for the Eighth Circuit, which affirmed the decision of the district court, on June 10, 1997, so that this Court might resolve an irreconcilable split between the Seventh and Tenth Circuits on one hand, and the Eighth, Eleventh and Fifth Circuits on the other, with respect to the employer obligation to continue to offer health insurance under COBRA when there is preexisting spousal/domestic partner coverage. There are two compelling reasons for review: first, the strong Congressional desire for national uniformity in enacting the Employee Retirement Income Security Act (ERISA), a goal often expressed by this Court in ERISA decisions, and second, importance of health insurance coverage concerns and the serious effect that loss of health insurance coverage may have on a large segment of the population.

OPINIONS BELOW

The opinion of the United States Court of Appeals for the Eighth Circuit, rendered June 10, 1997, is reported at 114 F.3d 1458, and is reprinted in the appendix hereto as A-1 to A-18. A petition for rehearing or rehearing en banc was denied July 30, 1997, and appears in the Appendix as A-19. The opinion of the United States District Court for the Eastern District of Missouri is published at 927 F.Supp. 352 and is reprinted in the Appendix at A-20 to A-36.

JURISDICTIONAL STATEMENT

The district court had jurisdiction of this action pursuant to 28 U.S.C. §1331 and 29 U.S.C. §§1132(a) and 1161. During the course of the proceedings in the district court, the original plaintiff died and the personal representative of his estate was substituted as party plaintiff. She is the petitioner herein. The

magistrate judge acting under consent given pursuant to 28 U.S.C. §636(c)(1) denied summary judgment to petitioner and on its own motion granted summary judgment in favor of defendants/respondents on Counts I and II. Final judgments were entered on those counts under Fed. R. Civ. P. 54(b).

An appeal was taken to the Eighth Circuit Court of Appeals pursuant to 28 U.S.C. §1291. The judgment of the Court of Appeals was entered June 10, 1997. Petitioner filed a petition for rehearing by the panel or, alternatively, for rehearing en banc. The Court of Appeals denied the petition July 30, 1997.

Pursuant to Supreme Court Rule 13.1, this petition has been filed within 90 days of the denial of rehearing. The jurisdiction of this Court is invoked pursuant to 28 U.S.C. §1254(1).

STATUTE INVOLVED

The Consolidated Omnibus Budget Reconciliation Act ("COBRA") 29 U.S.C. §§1161(a) and 1162(2)(D)(i), provides:

§1161 Plans must provide continuation coverage to certain individuals

(a) In general

The plan sponsor of each group health plan shall provide, in accordance with this part, that each qualified beneficiary who would lose coverage under the plan as a result of a qualifying event is entitled, under the plan, to elect, within the election period, continuation coverage under the plan.

§1162. Continuation coverage

For purposes of section 1161 of this title the term "continuation coverage" means coverage under the plan which meets the following requirements:

(2) Period of coverage

The coverage must extend for at least the period beginning on the date of the qualifying event and ending not earlier than the earliest of the following:

(D) Group health plan coverage or medicare entitlement

The date on which the qualified beneficiary first becomes, after the date of the election—

(i) covered under any other group health plan (as an employee or otherwise) "which does not contain any exclusion or limitation with regard to any pre-existing condition of such beneficiary", . . .

STATEMENT OF THE CASE

The petitioner's decedent, James Geissal, referred to as "James" in the Eighth Circuit's opinion, worked for respondent Moore Medical Corporation (Moore), and while so employed was entitled to health care benefits from a group plan established by Mr. Geissal's employer. Mr. Geissal's wife, the petitioner in this petition in her capacity as personal representative of his estate, worked for Trans World Airlines (TWA), which provided for its employees and their spouses health care benefits through its group health plan. The TWA plan was administered by Aetna Insurance Company. The Moore plan had no coordination-of-benefits provision, and a lifetime maximum for payments it would make. The plan sponsored by TWA made it secondary to payments by the Moore plan, and it too had a lifetime maximum limited to payments it alone would make. Had Mr. Geissal exceeded the maximum lifetime of the Moore plan, he would have immediately started receiving benefits from the TWA plan; he would not have to wait until his employment was terminated. He did not in fact exceed the maximum.

James Geissal suffered from cancer, and his employment was terminated by Moore. He had not exceeded his lifetime cap

imposed by the Moore plan at the time of his termination. That termination was a COBRA-qualifying event. At the time of termination, Moore and its plan administrator both assured Mr. Geissal of eligibility for COBRA continuation and encouraged him to so elect to continue his coverage and pay premiums. James Geissal exercised the right of election Moore offered and paid premiums to respondents under COBRA. He wanted to protect himself and his estate from the high cost of cutting-edge medical treatments to treat the cancer, and he was concerned that the maximum of lifetime benefits in only one plan may not be sufficient for the aggressive care he intended to fight his cancer. He also had in mind the fact that the deductibles under the TWA plan were greater. After accepting some six months of COBRA premiums, and as medical expenses for his cancer treatments were rising, respondents suddenly advised Mr. Geissal that he was not entitled to and ineligible for COBRA coverage; no bills for medical coverage were paid by the Moore plan. They proposed to pay back his premiums. Mr. Geissal instituted this action to secure his COBRA rights, in the district court pursuant to 28 U.S.C. §1331 and 29 U.S.C. §§1132(a) and 1161.

After filing his motion for summary judgment in the district court, Mr. Geissal succumbed to the cancer. His widow, petitioner herein, was appointed personal representative of his estate by the Circuit Court of St. Louis County (Probate Division), Missouri, and was allowed to be substituted in his place by order of the magistrate judge.

REASONS FOR GRANTING THE WRIT

I. There is an irreconcilable split in the circuits and a threat to both geographical uniformity of employer obligations under benefits law and to health of the persons adversely affected by the decisions of three circuits which do not permit COBRA continuation in the event of preexisting health benefits/insurance coverage provided by a collateral source, such as the spouse's employer

This case is compelling for review and resolution by this Court. The five circuits which have addressed the issue are irreconcilably split, as the Eighth Circuit in the instant case notes. *Geissal v. Moore Medical Corp.*, 114 F.3d 1458, 1465-66 (8th Cir. 1997). The Seventh and Tenth Circuits hold that preexisting spousal/domestic partner coverage does not fit the statutory definition unless one disregards the words "first" and "after" in 29 U.S.C. §1162(2)(D)(i), compelling COBRA continuation. *Lutheran Hospital of Indiana, Inc. v. Saint Joseph Medical Center*, 51 F.3d 1308 (7th Cir. 1995); *Oakley v. City of Longmont*, 890 F.2d 1128 (10th Cir. 1989). See also *King v. John Hancock Mutual Life Ins. Co.*, 500 N.W.2d 619 (S.D. 1993). In addition to the Eighth Circuit in the instant case, the Fifth and Eleventh Circuits attempt to read in some hidden Congressional meaning to sparse, hardly existent legislative history,[1] to disre-

[1] See T. H. Somers, "COBRA: An Incremental Approach to National Health Insurance," 5 J.Contemp. Health L. & Pol'y 141 (April, 1989). Under a heading entitled "COBRA: A 'Middle of the Night" Enactment?", he noted that Congress enacted COBRA "without deliberation and in the process of amending three distinct statutes," causing:

> a fair amount of regulatory confusion and bureaucratic tension. . . . Absent solid statutory or regulatory guidance for a legislative history that unravels COBRA's complexity, one commentator has asked whether COBRA was rationally considered, a 'middle of the night'

(Footnote 1 continued on next page)

gard the words written, holding COBRA does not compel continuation if there is preexisting coverage. *Brock v. Primedica, Inc.*, 904 F.2d 295 (5th Cir. 1990); *National Companies Health Benefit Plan v. St. Joseph's Hospital, Inc.*, 929 F.2d 1558 (11th Cir. 1991).

Any national employer who offers a health benefits package to its workers is compelled by decisions of the Seventh and Tenth Circuits to offer COBRA continuation to its employees in the states covered by those circuits, while for those employees sandwiched in between, the states within the Eighth Circuit, and to its Southern workers in states within the Fifth and Eleventh Circuits, that same employer does not have to offer the same continuation coverage or may withdraw it ab initio once it determines there was preexisting spousal/domestic partner coverage.

Several circuits have not yet addressed the issue, which puts not only beneficiaries in threat of having insufficient health care coverage, as the Fifth Circuit makes evident, *Brock v. Primedica, Inc.*, *supra*, but employers operating in those areas are in a quandary, especially when, if they elect to follow the views of the Eighth, Fifth and Eleventh Circuits, and it later turns out the particular circuit follows the Seventh and Tenth Circuits, they face not only restoration of benefits, but substantial daily penalties provided under 29 U.S.C. §1132(c)(1).

(Footnote 1 continued)

> addition to the Budget Reconciliation Act. [Footnote omitted] Indeed some might argue that COBRA is symptomatic of Congress' growing inclination to delegate unlimited legislative authority to the other branches of government. The absence of legislative direction, of course, is where federal agencies and, inevitably, the courts are often called upon to divine legislative will.

The author then intones, presciently, "we should expect much of the same in COBRA's future."

It was this compelling concern for national uniformity of results that led this Court to accept review in *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101 (1989). See also *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1, 11 (1987) (Congressional desire to avoid "patchwork scheme of regulation"). The fact that in *Firestone* it was the employer appealing for need for national uniformity in all its plants in various parts of the country, suffering different results depending upon the particular circuit, while here it is a single worker raising the same concerns for uniformity, should not skewer the need for this major issue to be resolved now. How health care is to be made available is far more a pressing issue nationally than severance pay. The Eighth Circuit below noted in the instant case,

> ...the federal courts have experienced significant difficulty in attempting to grasp the true meaning of 29 U.S.C. § 1162(2)(D)(i). Our efforts, though unquestionably well intentioned, have inevitably led to at least two separate and irreconcilable interpretations of the law. This deepening rift is extremely troublesome to us, especially given the proliferation of group health plans and the importance of guaranteeing equivalent protection to all ERISA beneficiaries throughout this nation. Accordingly, we suggest that some definitive action, originating either from Congress or the Supreme Court, might be appropriate.

The issue cries out for resolution now, as the Department of Labor considers issuing new guidelines on COBRA. See "Labor Department Considers Need for Guidance on COBRA Provisions," 66 U.S. Law Week 2185. Congress did not choose to clarify the statutory provision or did not see any need to clarify, when well after the decision of the Seventh Circuit in *Lutheran Hospital of Indiana, Inc. v. Saint Joseph Medical Center*, *supra*, and before the decision of the Eighth Circuit for which review is now sought, it enacted other changes to COBRA in Section 421

of the Health Insurance Portability and Accountability Act, Pub. L. 104-191, but made no change to §1162(2)(D)(i).

Resolution is also needed, for the creation of the legal fiction that the preexisting spousal/domestic partner policy comes into effect only "after" employment has been terminated, could threaten the worker's right as beneficiary of the spousal/dependent coverage to bring any action prior to the COBRA-qualifying event to challenge COB determinations or to determine his/her rights to future benefits in the plan of the spouse/domestic partner, expressly allowed to beneficiaries by 29 U.S.C. §1132(a)(1)(B). Such likely disenfranchisement based on a later fictional effective date merits examination by this Court in considering the split.

II. If there is to be an exception to a determination that §1162(2)(D)(i) provides that preexisting spousal coverage eliminates any COBRA obligation of the employer, there is similar compelling need for uniformity with respect to the nature of such exception, and who bears the burden of going forward and proof on such exception issue

The Fifth, Eighth and Eleventh Circuits all propose to allow exceptions, based on their views as to whether there is a "significant gap" between what benefits the employer provides and what is the coverage provided in the preexisting spousal/domestic partner policy. There is no legislative guidance (or warrant) whatsoever to establish what is a "significant gap," and there is no uniform judicial approach.

In the Eighth Circuit it used to be just how much was involved after the bills were incurred, as in *McGee v. Funderburg*, 17 F.3d 1122, 1126 (8th Cir. 1994) (*dicta*, $7,500 is a significant gap), but the instant decision for which review is sought now insists on a foresight test that district courts seem now to favor. See, *e.g.*, *Lutheran Hospital of Indiana, Inc. v. Saint Joseph Medical Center*, 845 F.Supp. 1275 (N.D. Ind. 1994), reversed, 51 F.3d 1308 (7th Cir. 1995); *Schlett v. Avco Financial Services, Inc.*, 20 EBC 2077, 2085-86 (N.D. Oh. 1996) ($7,000 actual gap irrelevant, review of cases).

Under *Brock v. Primedica, Inc.*, *supra*, one does not consider what the amount of the foreseeable expense might be and the adequacy of coverage, but solely to see if the condition was covered in both policies. That is also the view of the Eleventh Circuit. *National Companies Health Benefit Plan v. St. Joseph's Hospital, Inc.*, *supra*, 929 F.2d at 1569, 1571 (fact that lack of dual coverage leaves a gap of over $7,000 because preexisting policy did not pay all expenses, is irrelevant).

In contrast to the Eleventh Circuit, the Eighth Circuit talks not in terms of any particular condition, but in terms of "comparable group health programs," 114 F.3d at 1465, and calls for examination of overall plan terms, to see if the preexisting plan "offered appreciably fewer benefits . . . or limited coverage for treatment likely necessary for a cancer patient in James' condition." *Geissal v. Moore Medical Corp.*, *supra*, 114 F.3d at 1465. Citing with approval the dissent in *Lutheran Hospital of Indiana, Inc. v. Saint Joseph Medical Center*, *supra*, 51 F.3d at 1318, the Eighth Circuit talks approvingly of "potential of substantial liability" under the preexisting plan (called "new plan") "that does not exist under the old." 114 F.3d at 1465.

Hence, even amongst the "gap" courts there is no agreement as to just what or how to measure, putting employers in a quandary. And workers are now subject to a "quantum of proof necessary to demonstrate a significant gap in coverage," *ibid.*, a burden that Congress did not indicate should be borne by those it intended to protect.

For the same reasons expressed for review of the irreconcilable split in the circuits, that is, need for national uniformity, the effect of approach on health issues and the DOL guidelines, this

second question deserves addressing even if this Court accepts the fiction of the Eighth Circuit that the preexisting coverage did not come into being until after the occurrence of the COBRA qualifying event.

CONCLUSION

For the foregoing reasons, the petition for writ of certiorari should be granted.

Respectfully submitted,

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APPENDIX

APPENDIX A

UNITED STATES COURT OF APPEALS
FOR THE EIGHTH CIRCUIT

No. 96-2285

Bonnie L. Geissal, as beneficiary and representative of the Estate of James W. Geissal, deceased, individually and in a representative capacity on behalf of the Group Benefit Program of Moore Medical Corp.,

Plaintiff - Appellant,

v.

Moore Medical Corporation;
Group Benefit Plan of Moore Medical Corp.;
Herbert Walker,

Defendants - Appellees.

Appeal from the United States District Court
for the Eastern District of Missouri.

Submitted: December 11, 1996
Filed: June 10, 1997

Before FAGG, FLOYD R. GIBSON, and LOKEN, Circuit Judges.

FLOYD R. GIBSON, Circuit Judge.

James Geissal filed this suit against his former employer, its group health plan, and the plan administrator (collectively the "Plan"), claiming primarily that the Plan violated certain portions of the Comprehensive Omnibus Budget Reconciliation Act of 1986 ("COBRA"), as amended, *see* 29 U.S.C. §§ 1161-1169 (1994), when it rejected his efforts to obtain continuation insurance benefits following the termination of his employment. On

motion for partial summary judgment, the district court[1] determined that Geissal, who at the time of his discharge was also insured under a group health plan sponsored by his wife's employer, was not entitled to take advantage of the continuation coverage mandated by COBRA. The district court also concluded the record does not support Geissal's assertion that the Plan should be equitably estopped from denying him COBRA benefits. Bonnie Geissal, who was substituted as plaintiff upon James Geissal's death, appeals the district court's decision, and we affirm.

I. BACKGROUND

When Moore Medical Corporation ("Moore") fired James Geissal[2] on July 16, 1993, he had been employed by the company for a little over seven years. During his tenure with Moore, James, who suffered from cancer, participated in the group health plan the corporation offered to its employees. *See* 29 U.S.C. § 1167(1) (1994) (defining "group health plan" for purposes of COBRA's continuation requirements). At the same time, James was a beneficiary under a plan provided by his wife's employer, Trans World Airlines ("TWA"), through Aetna Life Insurance Company ("Aetna"). Put simply, then, James enjoyed "dual coverage" before he lost his job.

In an affidavit submitted to the district court, James stated that he was unhappy about the circumstances surrounding his termination and even requested, pursuant to Missouri law, a "service letter" from Moore detailing the grounds for his discharge.[3]

[1] The HONORABLE DAVID D. NOCE, United States Magistrate Judge for the Eastern District of Missouri, who presided over the case with the consent of the parties in accordance with 28 U.S.C. § 636(c) (1994).

[2] For ease of discussion, throughout the remainder of this opinion we often identify James Geissal by his given name, "James." We use the surname "Geissal" to refer to the appellant, Bonnie Geissal.

[3] The Missouri legislature requires certain corporate employers, upon request and under statutorily prescribed circumstances, to furnish disassociated employees a signed writing "truly stating for what cause, if any, such employee was discharged." Mo. Ann. Stat. § 290.140 (West 1993).

According to the affidavit, though, James ultimately declined to "consult with an attorney to investigate and to determine what rights and claims [he] might have [had] against Moore," Geissal's App. at 23, because Moore promised to afford him an opportunity under COBRA to maintain his health insurance. James further claimed that, based on these assurances, he failed to locate an alternative policy to supplement the insurance he received from his wife's employer.

After receiving an "election form" outlining his COBRA rights, James chose to receive continued coverage under Moore's group health plan. As such, James made premium payments, which Moore accepted, for approximately six months after his last day of work. Nonetheless, by letter dated January 27, 1994, the plan administrator informed James that he was ineligible for COBRA benefits because he was already covered under TWA's group policy. As a result, the insurer declared its intention to reimburse James for the premiums he had tendered, and it also returned billings that had been submitted by the cancer patient's medical care providers.

James subsequently initiated this suit, principally asserting that the Plan violated COBRA when it canceled his insurance coverage. Following limited discovery, James moved for summary judgment against the Plan on counts one and two of his four count Complaint. The district court denied James's motion and instead entered summary judgment in the Plan's favor on the two causes of action. *See Geissal v. Moore Med. Corp.*, 927 F. Supp. 352, 361 (E.D. Mo. 1996) (citing *Madewell v. Downs*, 68 F.3d 1030, 1048-50 (8th Cir. 1995) (recognizing a district court's prerogative to grant summary judgment *sua sponte* where the party against whom judgment will be entered has received adequate notice and an opportunity to respond)). In particular, the court decided that COBRA does not, in most cases, compel an employer to furnish continuation benefits to a discharged employee when the individual is also insured under another

group plan. *See id.* at 358-60. The court additionally determined that James had not proffered facts sufficient to substantiate his claim for equitable estoppel. *See id.* at 360-61. Consequently, the court dismissed counts one and two, but ordered additional proceedings relating to the remaining grounds for relief. Bonnie Geissal, who by this time had replaced her husband as plaintiff, petitioned the court to make appropriate findings under Rule 54(b) of the Federal Rules of Civil Procedure, thus permitting an immediate appeal from the partial grant of summary judgment. The Plan did not challenge the motion, and the court granted Geissal's request by entering final judgment on counts one and two and staying further action pending our resolution of this interlocutory appeal.[4]

II. DISCUSSION

A. COBRA

The "staggering budget deficits now facing the United States" prompted Congress to pass COBRA in 1986. S. Rep. No. 99-146, at 3 (1985), *reprinted in* 1986 U.S.C.C.A.N. 42, 43. Ever resourceful, Congress also used this massive piece of legislation as a vehicle to assuage its concern with "the growing number of Americans without any health insurance coverage and the decreasing willingness of our Nation's hospitals to provide care to those who cannot afford to pay." H.R. Rep. No. 99-241, pt. 1, at 44 (1985), *reprinted in* 1986 U.S.C.C.A.N. 579, 622. Namely, Congress included within COBRA amendments to the Employee Retirement Income Security Act of 1974 ("ERISA"), *see*

[4] Dubious of our jurisdiction, we instructed the parties to approach oral argument prepared to discuss the possible prematurity of this appeal. Though we regard this as an *extremely* close case, we are satisfied that the district court acted within its discretion when it authorized Rule 54(b) certification as to counts one and two of Geissal's four count Complaint. *See Hardie v. Cotter & Co.*, 819 F.2d 181, 182 (8th Cir. 1987)(reciting the standards applicable to entries of judgment under Rule 54(b)).

29 U.S.C. §§ 1001-1461 (1994), which require sponsors of group health plans to extend temporary continuation insurance benefits to individuals who lose coverage due to certain qualifying events, *see* 29 U.S.C. § 1161(a).

Normally, "qualified beneficiar[ies]," including employees and their spouses and dependents, *id.* § 1167(3)(A), are entitled to receive continuation coverage for eighteen or thirty-six months, depending upon the nature of the qualifying event, *see id.* § 1162(2)(A). Aware that this lingering obligation could prove burdensome to group health plans, however, Congress enacted exceptions that permit earlier termination of benefits if certain conditions are met. *See id.* § 1162(2)(B)-(E). Of present concern is the provision allowing cancellation of COBRA insurance on

> [t]he date on which the qualified beneficiary first becomes, after the date of the election [to obtain continuation benefits]—
>
> (i) covered under any other group health plan (as an employee or otherwise) which does not contain any exclusion or limitation with respect to any preexisting condition of such beneficiary . . . .

Id. § 1162(2)(D).[5]

The Plan banks on this language to support its decision to terminate James Geissal's coverage. Because James was a beneficiary under his wife's group health program with TWA, the Plan claims this statutory exception rendered it perfectly permissible to declare him ineligible for continuation benefits. Though Geissal does not deny that the TWA plan, administered through Aetna, constituted group health insurance which did not

[5] In the course of this opinion, we cite to the version of the statute applicable to the facts of this case. *Cf.* 29 U.S.C.A. §§ 1162(2)(D)(i), 1181-1191c (Supp. 1997) (containing recent amendments).

"contain any exclusion or limitation with respect to any preexisting condition," *id.* § 1162(2)(D)(i), she insists that the Plan violated COBRA when it canceled James's insurance. Purportedly seizing upon the "plain language" of the Act, Geissal contends that a person is disqualified from receiving continuation benefits only if he procures other coverage *after* he has chosen to secure COBRA insurance; otherwise, the individual does not *first* become covered "under any other group health plan" *after* the date of election. Under this reading of the exception, James retained his eligibility for continuation coverage because his status as a beneficiary under the TWA plan predated his discharge from Moore.

Geissal's interpretation of COBRA is not without supportive authority. The United States Court of Appeals for the Tenth Circuit, the first federal appellate tribunal to consider this question, has held that the exception allows termination of continuation benefits only if the beneficiary obtains other insurance after the date of election. *See Oakley v. City of Longmont*, 890 F.2d 1128, 1133 (10th Cir. 1989), *cert. denied*, 494 U.S. 1082 (1990).[6] Scrutinizing the disputed language "in light of the entire legislative scheme" enacted by Congress, *id.* at 1132-33, the Tenth Circuit concluded that the statute "contemplates continuation coverage to remain available to the covered employee despite a spouse's preexisting insurance policy," *id.* at 1133. The court explained:

> When we read the [exception's] introductory language in conjunction with "covered under any other group health plan (as an employee or otherwise)," we believe the plain meaning of this subsection cannot be construed to include a spouse's preexisting group plan as a condition to terminate continuation coverage. Indeed, [the appellant] did not "first become" covered under his wife's policy after the qualifying event that resulted in his termination from the City's employment. Nor did Congress intend a covered employee's termination to become a condition triggering "other" coverage under a spouse's preexisting group plan. Consequently, only when we read the language of subsection (i) to refer to other coverage occurring after the qualifying event, do we preserve its plain meaning and give effect to Congress' intent.

[6] A public employee was the plaintiff in *Oakley*, and the case thus arose under the Public Health Service Act rather than ERISA. The pertinent continuation coverage provisions in the two Acts are, for practical purposes, indistinguishable. *Compare* 42 U.S.C. §§ 300bb-1 to -8 (1994) *with* 29 U.S.C. §§ 1161-1169.

Id. at 1132 (quoting 42 U.S.C. § 300bb-2(2)(D)(i)).

More recently, a panel of the Seventh Circuit, with one judge dissenting, reached the same result, but for slightly different reasons. *See Lutheran Hosp., Inc. v. Business Men's Assurance Co. of Am.*, 51 F.3d 1308, 1312-13 (7th Cir. 1995). That court focused upon what it perceived to be Congressional intent to grant a displaced employee the opportunity to maintain his insurance "status quo." *See id.* The court in large part divined this motivation from the requirement that continuation coverage be "identical to the coverage provide[d] under the plan to similarly situated beneficiaries under the plan with respect to whom a qualifying event has not occurred." *Id.* at 1313 (quoting 29 U.S.C. § 1162(1))(alteration added). Where an individual is fortunate enough to possess dual coverage before the occurrence of a qualifying event, he will receive "identical" benefits after the event, and thereby preserve his health care status quo, only if given an opportunity to invoke COBRA continuation rights. *See id.* at 1312-13. Elaborating upon this theme, and accentuating its conception of the statute's "plain language," the court observed:

> The statute clearly provides that the employee's right to continuation coverage terminates only when he or she *first* becomes, *after* the election date, *covered* by any other

group health plan. The statute does not say that an employee is ineligible for continuation coverage if he or she is covered by a preexisting group health plan. . . . Therefore, an employee loses the right to continuation coverage only if he or she chooses after the election date to accept coverage under another group health plan.

* * *

The plain language of the statute dictates that an individual only loses COBRA eligibility if he or she chooses to accept alternative group health insurance after the qualifying event. By the terms of the statute, the individual has the choice whether to preserve the status quo and continue the prior level of coverage under COBRA or accept alternative coverage and discontinue COBRA. In either case, for the [mandatory] statutory period . . ., the individual is never forced to accept a lower level of health care coverage than he or she received as an employee before the qualifying event.

Id. at 1312; *see also King v. John Hancock Mut. Life Ins. Co.*, 500 N.W.2d 619, 621-23 (S.D. 1993) (adopting parallel interpretation of comparable COBRA exception).

The opinions of two other courts of appeals stand in direct contradiction to *Lutheran Hosp.* and *Oakley*. *See National Cos. Health Benefit Plan v. St. Joseph's Hosp., Inc.*, 929 F.2d 1558 (11th Cir. 1991); *Brock v. Primedica, Inc.*, 904 F.2d 295 (5th Cir. 1990). These tribunals have emphasized that Congress designed COBRA to provide security for those persons who, as a result of some disruption in their employment, are left without *any* health insurance. *See National Cos.*, 929 F.2d at 1569-70; *Brock*, 904 F.2d at 296. The continuation coverage compelled by COBRA offers limited relief to these individuals by granting them a reasonable amount of time to procure alternative insurance. *See National Cos.*, 929 F.2d at 1570. Once a person does, indeed,

become a beneficiary under another group health plan, the result desired by Congress is achieved, and continuation coverage becomes unnecessary and superfluous. *See id.* In recognition of this fact, the exception at issue allows an employer to cancel continuation coverage whenever an employee receiving those benefits obtains replacement insurance. *See id.* As viewed by the Eleventh Circuit, the provision "clearly includes employees covered under their spouses' preexisting group health plans. In such a setting, the concerns that motivated Congress' enactment of COBRA generally are not present; the employee has group health coverage." *Id.*

The Eleventh Circuit also rejected the notion that the statute's "plain language" commands a different result. Chief Judge Tjoflat, writing for the court, reasoned:

> Congress was concerned with the lack of group health coverage after an employee left his job; therefore, the relevant time period is that following his continuation-coverage election. In applying the termination provision at issue, then, it is clearly irrelevant whether an employee had other group health coverage prior to this election date — an employer cannot refuse to offer continuation coverage to a former employee simply because that ex-employee had other group health coverage during his employment. Instead, Congress allowed ERISA-plan sponsors to terminate continuation coverage only on the first date after the election date that the employee became covered under another group health plan. Thus, it is immaterial when the employee acquires other group health coverage; the only relevant question is when, after the election date, does that other coverage take effect. In the case of an employee covered by preexisting group health coverage, the terminating event occurs immediately; the first time after the election date that the employee becomes covered by a group health plan other than the employer's plan is the moment

after the election date. In effect, such an employee is ineligible for continuation coverage.

Id. Based on this analysis, the Eleventh Circuit held that an employee who is insured under another group health plan may opt for continuation benefits only if "there is a significant gap between the coverage afforded under his employer's plan and his preexisting plan." *Id.* at 1571. The existence of a significant gap in coverage gives rise to continuation rights because in that situation "the employee is not truly 'covered' by the preexisting group health plan." *Id.*

In dicta, we have previously described as "attractive" the position announced by the Eleventh Circuit on this issue. *see McGee v. Funderburg*, 17 F.3d 1122, 1124 (8th Cir. 1994), but in *McGee* we gave "greater significance [to] the definition of 'cover[age] under any other group health plan,'" *id.* We do, however, take this occasion to explicitly follow the approach adopted by the Eleventh Circuit.[7] Having comprehensively reviewed both the language of the relevant exception and its function within the larger framework of COBRA, along with what little legislative history is available to shed light on the subject, we find ourselves in disagreement with the Seventh Circuit's decision that continuation benefits were crafted to allow an individual to maintain his insurance "status quo." *See Lutheran Hosp.*, 51 F.3d at 1312-13. Rather, we are convinced that Congress was fundamentally interested in making affordable health care temporarily available to those who otherwise would find themselves "without any health insurance cover-

[7] Though the effective statutory language in *National Cos.* predated the 1989 amendments to COBRA, which are operative in the present appeal, this circumstance does not make the Eleventh Circuit's viewpoint any less appealing. *Cf. Teweleit v. Hartford Life & Accident Ins. Co.*, 43 F.3d 1005, 1010 (5th Cir. 1995)("The [1989] amendment did not change existing law but clarified and emphasized the original Congressional intent behind COBRA.").

age."[8] H.R. Rep. No. 99-241, pt. 1, at 44 (1985), *reprinted in* 1986 U.S.C.C.A.N. 579, 622. Consistent with this goal, COBRA confers upon displaced employees a chance to locate replacement insurance without suffering any lapse in coverage, but it also allows employers to cancel continuation benefits whenever the purpose underlying the statute is served. Specifically, COBRA authorizes the termination of continuation coverage on the day that a former employee becomes a beneficiary under "any other group health plan," 29 U.S.C. § 1162(2)(D)(i), and we think it is largely irrelevant under the Act whether the employee obtained that coverage before or after his COBRA rights are activated.[9] *Cf. Lutheran Hosp.*, 51 F.3d at 1315 (Coffey, J., dissenting)("The goal of COBRA . . . is to provide temporary health insurance to those people whose jobs are voluntarily or involuntarily terminated, and are without health insurance other than COBRA coverage. COBRA insurance is not, nor has it ever been intended to provide adjunct or double health insurance coverage for those who are covered under another pre-existing policy.")

[8] Of course, to the extent a person has no group health insurance independent of that required by COBRA, the statute does offer him the right to preserve the status quo of his health insurance. *See Lutheran Hosp.*, 51 F.3d at 1317 (Coffey, J., dissenting).

[9] In reaching an opposite result, both the Seventh and Tenth Circuits relied, in varying degrees, upon COBRA's instruction that continuation benefits be "identical to the coverage provided under the [employer's] plan to similarly situated beneficiaries under the plan." 29 U.S.C. § 1162(1); *see Lutheran Hosp.*, 51 F.3d at 1313; *Oakley*, 890 F.2d at 1133. With respect, we fail to see how this requirement, which prevents an employer from offering less favorable insurance to subscribers who invoke their continuation rights, impacts COBRA's termination clauses. True, continuation coverage must be indistinguishable from the insurance offered to other plan beneficiaries, but an employer is still allowed to cancel this coverage whenever a recipient of continuation benefits becomes "covered under any other group health plan." 29 U.S.C. § 1162(2)(D)(i); *see also Lutheran Hosp.*, 51 F.3d at 1317 n.4 (Coffey, J., dissenting)(questioning the Seventh Circuit's reliance on the "identical coverage" requirement).

To be sure, the exception under discussion permits early cancellation of benefits only when the employee "first becomes, after the date of the election," 29 U.S.C. § 1162(2)(D), covered under any other group health plan. Like the Eleventh Circuit, though, we do not consider this clause to be an impediment to the conclusion we reach today. The quoted language was not meant to absolutely insulate from the exception persons who enjoy preexisting insurance, but was merely intended to pinpoint the day on which the presence of that coverage becomes pertinent. In other words, it is only *after* the election date that an employee's status as a beneficiary under another group health plan will permit the termination of COBRA benefits. *See National Cos.*, 929 F.2d at 1570 ("[I]t is immaterial when the employee acquires other group health coverage; the only relevant question is when, after the election date, does that other coverage take effect."). To use this case as an example, the first time, *after the date of election*, that James Geissal became covered under his wife's plan with TWA was the very moment after the election date. As a consequence, it was well within Moore's rights to cancel James's COBRA benefits unless there was "a significant gap between the coverage afforded under [Moore's] plan and his preexisting plan." *Id.* at 1571. It is now incumbent upon us to decide whether such a significant gap was, in fact, present.[10]

[10] The significant gap test finds at least implicit support in the legislative history accompanying the 1989 amendments to ERISA. In that year, Congress clarified that an employee who obtains insurance under another group health plan is nonetheless entitled to continuation benefits if his additional coverage "contain[s] any exclusion or limitation with respect to any preexisting condition of such beneficiary." 29 U.S.C. § 1162(2)(D)(i). The House Ways and Means Committee reported that this extra language was tailored to effectuate the purpose of continuation coverage, "which was to reduce the extent to which certain events, such as the loss of one's job, *could create a significant gap in health coverage*." H.R. Rep. No. 101-247, at 145 (1989) (emphasis added), *reprinted in* 1989 U.S.C.C.A.N. 1906, 2923. One example of a gap in coverage "occurs when the new employer group health coverage excludes or limits coverage for a preexisting condition that is covered by the continuation coverage." *Id.*

In ascertaining the existence of a significant gap in coverage, our first order of business is to determine what considerations should guide this inquiry. Immediately following the inception of the "gap" test, courts tended to evaluate the issue by fixating upon the actual expenses incurred by the employee as a result of the COBRA cancellation. *See, e.g., McGee*, 17 F.3d at 1126 (mentioning, in dicta, that over $6,500 in personal liability caused by termination of COBRA benefits would constitute a significant gap); *National Cos.*, 929 F.2d at 1571 (explaining that a significant gap would occur where an employee, "despite his other coverage, will be liable personally for substantial medical expenses to his and his family's detriment"). With the passage of time, however, this methodology has been criticized as representative of an inappropriate *post hoc* determination which gives too little guidance to employers who must decide, on the front end, whether termination of COBRA benefits is warranted. *See, e.g., Lutheran Hosp.*, 51 F.3d at 1317 (Coffey, J., dissenting)("Both the district court and the majority agree that we should not engage in *post hoc* determinations of insurance policies and their coverage. Rather, the policies must be assessed at the time that a person has the right to elect COBRA benefits because of termination of employment."); *Schlett v. Avco Fin. Servs., Inc.*, 950 F. Supp. 823, 833 (N.D. Ohio 1996)("The *post hoc* position advocated by Plaintiffs . . . subjects the employer to an unacceptable degree of uncertainty as to its legal obligations."); *Taylor v. Kawneer Co. Comprehensive Med. Expense Plan for Salaried Employees*, 898 F. Supp. 667, 677 (W.D. Ark. 1995)("[W]e . . . have serious doubts that the mere existence of financial liability for medical expenses in and of itself qualifies as a significant gap in coverage.").

Upon reflection, and with the benefit of several years of case law developing the relevant standard, we agree that placing primary significance upon an employee's actual expenses is unhelpful to those who must administer ERISA plans and does

not adequately encompass other factors which have greater bearing on the presence of a significant gap. Therefore, we eschew this analysis in favor of a framework which, in our opinion, is less dependent upon hindsight and more responsive to the concerns which motivated Congress to enact COBRA. We believe a district court confronted with this question should measure the gap by comparing the policies' provisions in light of information available to the employer on the day of the COBRA election. To adjudge whether a significant gap existed on that date, thus entitling the employee to continuation coverage, the court should examine the policies "to determine their benefits, whether there is any exclusion or limitation on the patient's preexisting condition, and with a view to the treatment the beneficiary may foreseeably require." *Lutheran Hosp.*, 51 F.3d at 1318 (Coffey, J., dissenting)(quotation and emphasis omitted); *see also Schlett*, 950 F. Supp. at 833 ("[A] significant gap exists when coverage is excluded or limited for certain types of conditions or treatments, when viewed, at the time of election, in light of the benefits offered, preexisting condition exclusions, and the treatment the beneficiary may foreseeably require.").

In this case, Geissal has failed to carry her burden of proving there was a significant gap between the Moore and TWA plans. Based on the record before us, it is impossible for us to conclude that, on the election date, the TWA plan offered appreciably fewer benefits, excluded claims for any of James's preexisting ailments, or limited coverage for treatment likely necessary for a cancer patient in James's condition. To the contrary, it appears that TWA's insurance, while not completely identical to the Moore plan, provided comprehensive medical benefits to employees and their eligible dependents. Indeed, Geissal has satisfactorily identified only two differences between the plans: TWA's yearly deductible was $350 greater than the annual deductible under Moore's program, and the two plans had

separate lifetime maximums on benefits.[11] These rather insubstantial dissimilarities fall far short of the quantum of proof necessary to demonstrate a significant gap in coverage. *Cf. Lutheran Hosp.*, 51 F.3d at 1318 (Coffey, J., dissenting)("With respect to any dollar caps on coverage (all that really is at issue here), the 'gap' (if any) must be significant enough to alert a reasonable person of the potential for substantial personal liability under the new plan, that does not exist under the old." (quotation omitted)). Because James was insured under a comparable group health program, the Plan did not violate COBRA when it deemed him ineligible for continuation benefits.

We offer one final comment before proceeding to the remaining issue in this appeal. As the preceding discussion all too clearly illustrates, the federal courts have experienced significant difficulty in attempting to grasp the true meaning of 29 U.S.C. § 1162(2)(D)(i). Our efforts, though unquestionably well intentioned, have inevitably led to at least two separate and irreconcilable interpretations of the law. This deepening rift is extremely troublesome to us, especially given the proliferation of group health plans and the importance of guaranteeing equivalent protection to all ERISA beneficiaries throughout this nation. Accordingly, we suggest that some definitive action, originating either from Congress or the Supreme Court, might be appropriate.

B. Equitable Estoppel

Geissal also contends that the Plan is estopped from denying continuation coverage to James. For a considerable length of time, the availability in ERISA actions of this federal common law doctrine was an open question in our Circuit, *see, e.g.*,

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[11] Curiously, the record does not contain copies of the respective insurance policies.

Jensen v. SIPCO, Inc., 38 F.3d 945, 953 (8th Cir. 1994)("[W]e have left open the question whether equitable estoppel will ever give rise to an ERISA claim . . . ."), *cert. denied*, 115 S. Ct. 1428 (1995), but we recently confirmed that "[c]ourts may apply the doctrine of estoppel in ERISA cases only to interpret ambiguous plan terms," *Fink v. Union Cent. Life Ins. Co.*, 94 F.3d 489, 492 (8th Cir. 1996). The seminal issue in this appeal involves the Plan's interpretation and application of COBRA's continuation coverage provisions, statutory terms which are automatically included within every ERISA plan. *See* 29 U.S.C. § 1161(a) ("The plan sponsor . . . shall provide . . . continuation coverage under the plan."). It is safe to say that reasonable persons could come to conflicting conclusions regarding the import of these COBRA provisions, as the meaning of the statute has fairly evenly divided the federal courts of appeals that have addressed the question. *See National Cos.*, 929 F.2d at 1572 ("[T]he meaning and effect of COBRA's and the Tax Reform Act's amendments to ERISA is something about which reasonable persons can differ."). In the current appeal, then, Geissal challenges the Plan's interpretation of ambiguous components of an ERISA policy, and she has thus presented a cognizable claim of equitable estoppel. *See id.*

The principle of estoppel precludes a party from denying a representation upon which another person has reasonably and detrimentally relied. *See Farley v. Benefit Trust Life Ins. Co.*, 979 F.2d 653, 659 (8th Cir. 1992). According to Geissal, the Plan assured James that he was entitled to continuation coverage, and he relied on the Plan's representations by neglecting to obtain other insurance and by choosing not to pursue various legal remedies against his former employer. Geissal's claim founders, however, because she has not adverted to facts establishing that James's alleged reliance was detrimental. To succeed on an equitable estoppel claim premised upon foregone insurance coverage, a plaintiff must demonstrate that alternative insurance was available. *See Smith v. Hartford Ins. Group*, 6 F.3d 131, 137

(3d Cir. 1993)(deciding under similar circumstances that a party proves detrimental reliance by demonstrating that he could have obtained other insurance which covered his illness); *cf. National Cos.*, 929 F.2d at 1574 (discerning detrimental reliance where the plaintiffs "had, in fact, found another insurance company willing to cover [the beneficiary's medical condition]"). Geissal has not made this showing, but has merely proffered a conclusory contention that James surely would have been able to purchase *some* supplemental policy. This is insufficient to withstand summary judgment. *See Smith*, 6 F.3d at 137.

Likewise, Geissal has not shown that James suffered a concrete injury attributable to his failure to seek legal redress based on the termination of his employment. It is not enough to assert, as Geissal has, that James "felt Moore had been very unfair in discharging [him]," Geissal's App. at 23, and that he "gave some thought to whether [he] should consult with an attorney to investigate and to determine what rights and claims [he] might have [had] against Moore," *id.* Instead, as an absolute minimum to overcome summary judgment, an estoppel plaintiff must point to some facts which indicate that the lost causes of action were meritorious. Geissal has not even begun to satisfy this burden, for the record before us is completely bereft of any materials detailing the nature of James's employment with Moore or the circumstances surrounding his discharge. Consequently, because Geissal has not substantiated her allegations of detrimental reliance, we hold that the district court was correct in summarily dismissing the equitable estoppel claim.

III. CONCLUSION

The Plan did not violate COBRA when it terminated James's continuation insurance coverage, and the record does not support Geissal's contention that the Plan should be equitably estopped from denying coverage. As such, we affirm the district court's entry of partial summary judgment for the Plan.

AFFIRMED.

A true copy.

Attest:

CLERK, U. S. COURT OF
APPEALS, EIGHTH CIRCUIT.

APPENDIX B

UNITED STATES COURT OF APPEALS
FOR THE EIGHTH CIRCUIT

No. 96-2285 EMSL

Bonnie L. Geisal, etc.,
Appellant,

vs.

Moore Medical Corporation, et al.,
Appellees.

Order Denying Petition for Rehearing
and Suggestion for Rehearing En Banc

The suggestion for rehearing en banc is denied. The petition for rehearing by the panel is also denied.

July 30, 1997

Order Entered at the Direction of the Court:
/s/ Michael E. Gans
Clerk, U.S. Court of Appeals, Eighth Circuit

APPENDIX C

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF MISSOURI
EASTERN DIVISION

No. 4:94 CV 1263 DDN

BONNIE L. GIESSAL,[1]
Plaintiff,

v.

MOORE MEDICAL CORP., et al.,
Defendants.

[Filed: March 19, 1996]

MEMORANDUM

This matter is before the Court upon the plaintiff's motion for partial summary judgment (Doc. No. 20). The parties have consented to the jurisdiction to the United States Magistrate Judge pursuant to 28 U.S.C. § 636(c).

This case involves the continuation coverage provisions of the Employee Retirement Income Security Act of 1974 (ERISA), as amended by the Comprehensive Omnibus Budget Reconciliation Act of 1986 (COBRA), 29 U.S.C. § 1001 *et seq.* Plaintiff is Bonnie L. Geissal, wife and personal representative of the estate of James W. Geissal, who is now deceased. Defendants are Moore Medical Corporation, Group Benefit Plan of Moore Medical Group and Herbert Walker. On plaintiff's motion, Sedgwick Nobel Lowndes, originally named as a defendant, was dismissed without prejudice by order of the Court on November 8, 1994.

[1] Upon the death of plaintiff James W. Geissal, Bonnie L. Geissal, personal representative of the estate of James W. Geissal, was substituted on November 1, 1995, as party plaintiff. Fed. R. Civ. P. 25(a). References to plaintiff in the masculine in this Memorandum are to decedent.

Count I alleges that defendants violated COBRA by failing to provide continuation insurance coverage once Moore terminated Geissal's employment. Count II alleges that defendants are estopped from denying coverage because at the time of Geissal's termination, defendants made misrepresentations that made him believe that he was entitled to COBRA continuation and would have insurance coverage. Plaintiff alleges that Geissal relied on these representations and continued to pay the amount required for COBRA continuation. Count III alleges waiver, in that, by accepting Geissal's payments, defendants waived any differing construction or interpretation of ERISA plan documents. Count IV, which is not the subject of the pending motion, alleges that Herbert Walker, as plan administrator, failed to provide requested plan documents as required by statute.

Plaintiff has moved for partial summary judgment on the issue of defendants' obligation to provide COBRA coverage.

The following facts are without dispute:

FACTS

1. On July 16, 1993, Moore Medical Corp. (Moore or Moore Medical) terminated James Geissal. (Geissal Affidavit, filed June 5, 1995, at ¶ 8; Defendants' Answer, filed July 28, 1994.) At the time of his termination, Geissal was 62 years old and had cancer. (Geissal Aff. at ¶¶ 2, 5.) During his employment at Moore, Geissal was a participant in a health benefits plan, the Group Benefit Plan of Moore Medical Corp., sponsored by Moore for its employees. (Geissal Aff. at ¶ 4; Complaint at ¶ 9; Answer at ¶ 9.)

2. Moore Medical Corp. is an employer and the plan sponsor, within the meaning of 29 U.S.C. § 1102(5) and (16)(B), of defendant Group Benefit Plan (Plan) of Moore Medical Corp. The plan is an employee welfare benefit plan as defined in 29 U.S.C. § 1002(1). Defendant Group Benefit Plan of Moore

Medical Corp. provides for the payment and reimbursement to plan participants of various medical expenses and is a group health plan as defined 29 U.S.C. § 1167(1). (Complaint at ¶¶ 3, 4; Answer at ¶¶ 3, 4.)

3. While Geissal was employed at Moore, his wife, Bonnie, was employed by Trans World Airlines (TWA). (Complaint at ¶ 11; Answer at ¶ 11; Geissal Aff. at ¶ 6.) By reason of Bonnie Geissal's employment at TWA, James Giessal was a covered dependent eligible for coverage under the health insurance policy issued by Aetna Life Insurance Company, which was the health provider or third-party administrator under the TWA plan provided by TWA for its employees. (Geissal Aff. at ¶ 6, 15.) Geissal's coverage through his wife's plan preceded Geissal's termination by Moore. (Complaint at ¶ 11.)

4. Upon Geissal's termination at Moore Medical, Geissal received a notice of his right under COBRA to continue health insurance coverage under Moore's benefit plan. He accepted Moore's offer and elected to continue receiving group health coverage under Moore's Plan. He began making premium payments. (Geissal Aff. at ¶ 14.) The defendant accepted the payments. Approximately six months after his termination, by letter dated January 27, 1994, defendants informed Geissal that they had determined he was not entitled to COBRA coverage because he was already covered under a group policy with Aetna. (Geissal Aff. at ¶ 15.) Geissal was told that the premiums he had already paid would be returned and that those who provided him with medical care during that period would not be paid by the Plan and their billings would be returned to those who had provided medical care to him. (Geissal Aff. at ¶ 15.)

5. Moore's plan had an annual deductible of $150. It also provided for a lifetime maximum amount of benefits. (Geissal Aff. at ¶ 5.) TWA's plan through Aetna had an annual deductible of $500 per year per person and also provided a lifetime maximum amount of benefits. (Geissal Aff. at ¶ 6.)

6. At the time Geissal was terminated, he requested and received a service letter pursuant to Missouri Rev. Stat. § 290.140. (Geissal Aff. at ¶¶ 8, 10b.) At the time he was terminated, he considered whether he should consult an attorney to investigate what rights and claims he might have against Moore because he felt he was unfairly terminated. (Geissal Aff. at ¶ 10.) Geissal decided not to do so, because his main concern was that he have full and adequate health insurance. (Geissal Aff. at ¶ 10a.) Moore representatives encouraged him to make the COBRA election, which did much to assuage his feelings about his discharge. (Geissal Aff. at ¶ 10b.) At about this time, and shortly after the issuance of the service letter, the Plan or its reinsurer were making large payments for medical care provided to Geissal prior to his termination. (Geissal Aff. at ¶ 10c.) Because he was offered the COBRA continuation coverage, Geissal did not look for another insurance carrier. (Geissal Aff. at ¶ 11.)

DISCUSSION

Plaintiff has moved for partial summary judgment on the issue of defendants' obligation to provide COBRA coverage. Plaintiff states that Counts I II and III are related to that issue. However, plaintiff has not argued the issue of waiver, which is the basis for Count III. Plaintiff states that a finding of liability on Count I would moot Counts II and III.

This Court must grant summary judgment if, based upon the pleadings, admissions, depositions and affidavits, there exists no genuine issue of material fact and the moving party is entitled to judgment as a matter of law. Fed. R. Civ. P. 56(c); *Celotex Corporation v. Catrett*, 477 U.S. 317, 322 (1986); *Board of Education. Island Trees Union Free School Dist. v. Pico*, 457 U.S. 853, 863 (1982). The moving party must initially demonstrate the absence of an issue for trial. *Celotex Corporation*, 477 U.S. at 323. Any doubt as to the existence of a material fact must be resolved in favor of the party opposing the motion. *Board of Education v. Pico*, 457 U.S. at 863.

Nevertheless, once a motion is properly made and supported, the non-moving party may not rest upon the allegations in his pleadings but must instead set forth specific facts showing that there is a genuine issue of material fact for trial. Fed. R. Civ. P. 56(e); *Buford v. Tremayne*, 747 F.2d 445, 447 (8th Cir. 1984). Summary judgment must be granted to the movant if, after adequate time for discovery, the non-moving party fails to produce any proof to establish an element essential to the party's case and upon which the party will bear the burden of proof at trial. *Celotex Corporation*, 477 U.S. at 322-24.

In response to the motion, defendants have raised several issues. First, defendants argue that the plaintiff lacks standing to maintain the instant lawsuit because plaintiff has no economic damages. Based upon the discovery supplied by plaintiff and Aetna, which was the group insurance carrier under the spouse's preexisting health benefit plan, defendants assert that all of plaintiff's medical bills for "covered expenses" during the relevant period were paid by Aetna. Therefore, defendants claim, plaintiff has no claim for compensatory damages or other type of damages because he has suffered no damages. The Court nevertheless concludes that plaintiff has standing to bring this lawsuit for relief other than compensatory damages. *See* 29 U.S.C. § 1132(a)(1).

Second, defendants argue that a necessary party needed for complete adjudication pursuant to Federal Rule of Civil Procedure 19(a) is not before the Court. Defendants argue that the real party in interest is Aetna, the health provider for the TWA plan, and TWA, Bonnie Geissal's employer. Defendants argue that the question is whether Moore or Aetna should pay for the covered medical expenses during the COBRA continuation period. Defendants argue that if the Court were to hold that Moore should have provided COBRA coverage to Geissal and that such policy was primary to Aetna's policy, then Aetna should be reimbursed by Moore for all "covered expenses"

incurred by Geissal during the COBRA period. Further, the plaintiff would owe the Moore health plan $2,673.18 for 18 months of COBRA coverage. They argue that there is a possibility of a double recovery for plaintiff.

Plaintiff, in response, argues that defendants have waived the defense of failure to join a necessary party. However, because this defense can be raised as an issue at a trial on the merits, *see* Federal Rule of Civil Procedure 12(h)(2), the question of whether there is a genuine issue for trial with regard to this defense can appropriately be raised on a motion for summary judgment. *See Kornblum v. St. Louis County*, 48 F.3d 1031, 1038 (8th Cir.), *opinion vacated on other grounds*, 72 F.3d 661 (8th Cir. 1995).

The question of whether a party must be joined is examined under Federal Rule of Civil Procedure 19(a), which states in pertinent part:

> A person who is subject to service of process and whose joinder will not deprive the court of jurisdiction over the subject matter of the action shall be joined as a party in the action if (1) in the person's absence complete relief cannot be accorded among those already parties, or (2) the person claims an interest relating to the subject of the action and is so situated that the disposition of the action in the person's absence may (i) as a practical matter impair or impede the person's ability to protect that interest or (ii) leave any of the persons already parties subject to a substantial risk of incurring double, multiple, or otherwise inconsistent obligations by reason of the claimed interest.

Aetna is not a necessary party under the first subsection of Rule 19(a), because complete relief may be granted between Moore and plaintiff without Aetna's joinder. Moore may be required to continue coverage, in consideration for premiums paid. Because Aetna has already paid claims, its joinder is not necessary in order for plaintiff to obtain relief from Moore.

Therefore, defendants must rely on Rule 19(a)(2), which requires a finding that Aetna "claims an interest relating to the subject matter of the action." Assuming that Aetna "claims" such an interest, the remaining requirements of Rule 19(a)(2) are not met. Aetna's absence from this case will not impair or impede its ability to protect that interest. If the Court decides that Moore should have provided COBRA coverage, Aetna could decide what future recourse, if any, to take. The possibility of potential litigation is irrelevant to the criteria of Rule 19. "The focus is on relief between the parties and not on the speculative possibility of further litigation between a party and an absent person." *LLC Corp. v. Pension Benefit Guaranty Corp.*, 703 F.2d 301, 305 (8th Cir. 1983). In addition, a determination of the case in the absence of Aetna will not subject Moore to the risk of inconsistent or double obligations.

Third, defendants argue that the Court cannot grant relief against them unless it finds that the Moore health plan was primary to the Aetna health plan. This determination can be made upon adequate discovery, without Aetna's presence as a party.

The cardinal issue between the present parties is whether James Geissal's preexisting (Aetna) insurance coverage made him ineligible for continuation coverage with the Fund upon his termination. The resolution of that issue is one of statutory interpretation. ERISA, as amended by the Consolidated Omnibus Budget Reconciliation Act (COBRA), 29 U.S.C. § 1161-1168, requires employers to offer continuation coverage to certain categories of departing employees. COBRA specifies the circumstances which entitle an employer to terminate continuation coverage. The termination provision at issue in this case is as follows:

> The coverage must extend for at least the period beginning on the date of the qualifying event and ending not earlier than the earliest of the following:

* * *

> (D) The date on which the qualified beneficiary first becomes, after the date of the election—
>
> (i) covered under any other group health plan (as an employee or otherwise) 'which does not contain any exclusion or limitation with respect to any preexisting condition of such beneficiary.'

29 U.S.C. § 1162(2)(D)(i).

Plaintiff argues that the plain language of the statute mandates that only other group coverage which is obtained *after* the date of the election can preclude COBRA entitlement and selection. Therefore, because Geissal's coverage under his wife's plan existed *before* he elected the COBRA continuation plan, plaintiff argues that James Geissal is entitled to continuation coverage under the Moore Plan.

In interpreting a statute, a Court is required to look to the plain language of the statute, give significance to the statute as a whole, and to examine the purpose and intent of a statute when deciding what its terms mean. *Commissioner of Internal Revenue v. Engle*, 464 U.S. 206, 217 (1984); *Richards v. United States*, 369 U.S. 1, 11 (1962); *National Labor Relations Board v. Lion Oil Co.*, 352 U.S. 282, 289-90 (1957); *United States Department of Health and Human Services v. Smith*, 807 F.2d 122, 126-27 (8th Cir. 1986).

Five Circuit Courts of Appeals have considered whether COBRA authorizes an employer to withhold continuation coverage when the departing employee has dual coverage throughout his employment and therefore has a continuing source of coverage when he resigns or is terminated. *See Lutheran Hospital of Indiana, Inc. v. Business Men's Assurance Co. of America*, 51 F.3d 1308 (7th Cir. 1995); *McGee v. Funderberg*, 17 F.3d 1122 (8th Cir. 1994); *National Companies Health Benefit Plan*

v. St. Joseph's Hospital, Inc., 929 F.2d 1558 (11th Cir. 1991); *Brock v. Primedica, Inc.*, 904 F.2d 295 (5th Cir. 1990); *Oakley v. City of Longmont*, 890 F.2d 1128 (10th Cir. 1989), *cert. denied*, 494 U.S. 1082 (1990).

The Tenth Circuit was the first circuit to address the issue in *Oakley*.[2] At the time of plaintiff's termination, he had insurance under his employer and was also a dependent under his wife's group health plan. However, his wife's plan, unlike his employer's plan, did not cover the costs of the medical treatment he needed. The court found that the plain meaning of the statute "cannot be construed to include a spouse's preexisting group plan as a condition to terminate continuation coverage." *Oakley*, 890 F.2d at 1132. The court read the language of subsection (i) to refer to other coverage occurring *after* the qualifying event. *Id.* (emphasis added).

In Brock, the plaintiff elected continuation coverage when she was terminated. Both before and after her termination, she also was covered as a dependent on her husband's group health insurance plan. The Fifth Circuit held that plaintiff was not entitled to continuation coverage under COBRA. *Brock*, 904 F.2d at 297.

In *National Companies*, the plaintiff elected, upon his resignation, to continue receiving group health coverage under his employer's plan. Both before and after his resignation, he was also covered under the group health plan of his wife's employer. Plaintiff had paid premiums and the premiums were accepted. The Eleventh Circuit held that an ERISA provider is not required to offer continuation coverage to an employee or his dependents who are covered under a preexisting group health plan. *National Companies*, 929 F.2d at 1566. The court held that

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[2] The actual provision at issue in *Oakley* was 42 U.S.C. § 300bb-2(2)(D)(1), which covers public employees. However, it is identical to the provision at issue in this case.

> it is immaterial when the employee acquires other group health coverage; the only relevant question is when, after the election date, does that other coverage take effect. In the case of an employee covered by preexisting group health coverage, the terminating event occurs immediately; the first time after the election date that the employee becomes covered by a group health plan other than the employer's plan is the moment after the election date. In effect, such an employee is ineligible for continuation coverage.

Id. at 1570.

In *McGee*, the plaintiff's deceased husband had health insurance as a benefit of his membership in a union. Upon his retirement, he elected continuation health coverage under COBRA and paid his monthly premiums. When he was diagnosed with cancer and began submitting claims for payment of medical expenses, the Fund terminated COBRA coverage on the basis that he was covered by another group health care plan. *McGee*, 17 F.3d at 1123. The district court adopted the rationale of the Eleventh Circuit in *National Companies*. On appeal, the Eighth Circuit found the Eleventh Circuit's reasoning "attractive," but concluded that it need not decide the question of whether preexisting coverage defeated the employee's eligibility for continuation coverage. *Id.* at 1124.

In *Lutheran*, plaintiff was covered under both her employer's and her husband's group health plans. Plaintiff had a neurological disorder. She was then laid off. Her employer's insurance company told her she would not be eligible for COBRA coverage because of her preexisting coverage under her husband's plan. *Lutheran*, 51 F.3d at 1310 & n.1. The court held that the clear language of the statute provides that an employee loses the right to continuation coverage only if he chooses after the election date to accept coverage under another group health plan. *Id.* at 1312. Therefore, preexisting coverage would not make an employee ineligible for COBRA coverage. "The statutory dis-

tinction between preexisting and after-acquired health care coverage is reasonable and facilitates the preservation of the beneficiary's health care status quo." *Id.*

The undersigned finds the reasoning of the Eleventh Circuit persuasive and therefore holds that James Geissal's preexisting coverage under his wife's plan constitutes coverage "under any other group health plan" for purposes of 29 U.S.C. § 1162(2)(D)(i).

The fact that Geissal had other coverage is not entirely dispositive, however. According to the plain language of the statute, if the other coverage contains an "exclusion or limitation with respect to any preexisting condition of [the] beneficiary," the employee may be eligible for continuation coverage.

The question is whether there was a gap between the coverage offered by the employer and that offered by the other insurance. Circuit Courts of Appeal have examined the relative coverage available to the beneficiary under both plans.

In *Oakley*, the plaintiff sought coverage for rehabilitation therapy for a brain injury. This treatment was covered under the plan provided by his former employer but was not covered under his spouse's plan. *Oakley*, 890 F.2d at 1130. The court held that plaintiff's coverage under his spouse's plan did not render him ineligible for continuation coverage from his former employer. In dicta, the Tenth Circuit noted that there was a gap between plaintiff's coverage under his employer's plan and his coverage under his wife's plan. *Id.* at 1133. The court noted that "the facts of this case illustrate the precise gap in coverage which troubled Congress;" in other words, forcing the plaintiff's family to pay for the treatment of his catastrophic injury would put plaintiff and his family at risk and jeopardized his treatment. *Id.* at 1133.

In *Brock*, the Fifth Circuit held that preexisting coverage rendered a departing employee ineligible for continuation coverage. However, the court also noted that there was no "gap" in plaintiff's coverage under the two plans. Specifically, the court noted that plaintiff was covered under both plans for the type of medical problem for which she later claimed benefits. *Brock*, 904 F.2d at 297.

The Eleventh Circuit showed a similar concern in *National Companies* when it examined the character of plaintiff's coverage under his former employer's plan and under his spouse's preexisting plan. *National*, 929 F.2d at 1571. While the court held that an employer was not required to provide continuation coverage to an employee who was covered under a preexisting group health plan, it also held that an employee may be entitled to receive continuation coverage under his previous employer's plan, if there is a significant gap between the employer's plan and the preexisting plan. *Id.* at 1571. If there is a significant gap in coverage such that the employee would become personally liable for substantial medical expenses to his family's detriment, the employee would not truly be "covered" under the preexisting plan. *Id.* The court noted that Congress' purpose in enacting COBRA was to respond to "the growing number of Americans without any health insurance coverage and the decreasing willingness of our Nation's hospitals to provide care to those who cannot afford to pay." *National*, 929 F.2d at 1567 (quoting H.R. Rep. No. 241, 99th Cong., 2d Sess. 44, *reprinted in* 1986 U.S.C.C.A.N. 579, 622). The court concluded that denial of continuation coverage when the employee's only other coverage does not truly cover the employee would frustrate Congress' intentions. *Id.*

In *McGee*, the Eighth Circuit noted in dicta that a significant gap between coverage afforded under the employer's plan and that afforded under the preexisting plan would entitle plaintiff to COBRA coverage. *McGee*, 17 F.3d at 1126. The court quoted *National* for the proposition that when a gap in coverage exists, then the employee is not truly covered by the preexisting group

health plan. *Id.* The court found that there was a significant gap because plaintiff remained personally liable for more than $7,500 under the preexisting plan, while under her employer's plan she would have been personally liable for only $1,000 in medical expenses. *Id.*

In this case, plaintiff maintains that there is a significant gap between the coverage provided by Moore and that provided by the preexisting plan because (1) Moore's plan had an annual deductible of $150 for covered medical services and treatments that Geissal needed, while Aetna's plan had an annual deductible of $500 per year per person; (2) Moore's plan had a lifetime maximum only as to payments made by the Plan and Aetna's plan had a lifetime maximum as to payments made by Aetna; therefore, before his termination Geissal had the benefit of two maximums; (3) coverage of some kinds of care were different, with coverage under Moore's plan being more extensive. (Affidavit of James Geissal, filed June 5, 1995, at ¶¶ 5-7.)

Plaintiff does not allege that James Geissal suffered from a preexisting condition that was not covered under Aetna's plan. Plaintiff does not allege that Geissal's condition was not covered by Aetna. Although the record is unclear about the exact amount of benefits paid or the extent of coverage, there is no dispute that benefits were in fact paid. The only difference between the two policies that Geissal asserted in his affidavit is the amount of deductible. This is not a significant gap. *See National*, 929 F.2d at 1571. A significant gap in coverage exists when coverage is excluded or limited for certain types of conditions or treatments. *See, e.g., Brock v. Primedica, Inc.*, 904 F.2d 295, 297 (5th Cir. 1990). Plaintiff has provided no evidence that coverage under the TWA plan was excluded or limited for Geissal's condition.

Plaintiff argues that, even if Moore was not required to provide continuation coverage to James Geissal, it is estopped from denying such coverage. *See National*, 929 F.2d at 1571-74.

Plaintiff alleges a federal common law claim of estoppel in Count II.[3]

The elements of equitable estoppel, as defined by federal common law, are that (1) the party to be estopped misrepresented material facts; (2) the party to be estopped was aware of the true facts; (3) the party to be estopped intended that the misrepresentation be acted on or had reason to believe the party asserting the estoppel would rely on it; (4) the party asserting estoppel did not know, nor should it have known, the true facts; and (5) the party asserting the estoppel reasonably and detrimentally relied on the misrepresentation. *Heckler v. Community Health Services, Inc.*, 467 U.S. 51, 59 (1984); *National*, 929 F.2d at 1572; *United States v. Aetna Casualty & Surety Co.*, 480 F.2d 1095, 1099 (8th Cir. 1973).

Plaintiff argues that Geissal was offered continuation coverage, (Aff. at ¶¶ 10b, 12) and that he relied upon that offer to his detriment. (Aff. at 10, 11). He stated that he did not look for other insurance, knowing how weak TWA was financially and how he needed more than what TWA provided, and he did not pursue investigation as to defendants' possible misconduct in terminating him.

In *National*, the court found that the employer had misrepresented to plaintiff that he was entitled to and would receive continuation coverage, in a memorandum explaining continuation coverage; that by accepting premium payments for four months, the company continually assured plaintiff that the Plan was providing him with coverage; that Plan representatives knew or believed, prior to plaintiff's resignation, that plaintiff

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[3] The Eighth Circuit has not recognized a federal common law action for equitable estoppel, although it has been suggested that it would do so in certain circumstances. *Slice v. Sons of Norway*, 34 F.3d 630, 633-34 (8th Cir. 1994); *Coonce v. Aetna Life Insurance Co.*, 777 F. Supp. 759, 769-70 (W.D. Mo. 1991). *See also McGee*, 17 F.3d at 1126.

was ineligible for continuation coverage because of his preexisting coverage; that plaintiff relied on the company's memorandum notifying him of his rights with respect to continuation coverage; that plaintiff was unaware of the true facts because there was no evidence that plaintiff knew he was not entitled to continuation coverage; and that plaintiff relied on those representations by deciding not to accept coverage under another policy when he learned he would be entitled to continuation coverage. In addition, plaintiff incurred personal liability for $6,700 in medical expenses he would not have incurred had he maintained dual coverage. *National*, 929 F.2d at 1573-74.

In *McGee*, McGee elected, upon retirement, to continue coverage and he paid monthly premiums. When he was diagnosed with cancer and began to submit claims for payment of medical expenses, his employer's plan terminated COBRA coverage. *Id.* at 1123. McGee continued to tender premium payments until he died, but the Fund refused to accept the payments. *Id.* The Eighth Circuit indicated in dicta that the doctrine of equitable estoppel might be applicable to such a case, in which the employer's plan accepted the employee's premiums for months, denied coverage when he became sick, and he relied to his detriment on the Fund's representations that COBRA coverage would be afforded. *McGee*, 17 F.3d at 1126.

In this case, there is no dispute that defendants told Geissal he was entitled to continuation coverage. In addition, defendants accepted Geissal's premium payments for about six months, from the date of termination, July 16, 1993, until he was notified on January 27, 1994, that Moore had determined he was not entitled to COBRA coverage. There is no evidence that Plan representatives previously knew he was covered by a preexisting policy. However, the Court will assume that the defendants had constructive knowledge because of their obligation to know every ERISA provision and to determine employees' rights. *National*, 929 F.2d at 1573 n.15. There is no dispute that Geissal

relied on the company's notification that he was entitled to continuation coverage. There also is no dispute that Geissal was unaware of the true facts, *e.g.*, that the preexisting policy disqualified him from COBRA coverage.

However, while plaintiff asserts that Geissal relied on those representations, there is no evidence that he relied on them to his detriment. Plaintiff has not shown that Geissal suffered any economic loss. *See National*, 929 F.2d at 1574 n.16. Geissal stated that, although he gave some thought to whether he should consult an attorney to investigate what rights and claims he may have had against Moore concerning his termination and he knew that he could complain to government agencies about his termination, he decided not to do so because his main concern was that he have full and adequate health insurance. (Geissal Aff. at ¶¶ 10 and 10a.) He further stated that Moore representatives encouraged him to make the COBRA election offered by Moore, and that conduct did much to assuage his feelings about his discharge, so much so that he decided against taking any investigative steps beyond requesting a service letter. (Geissal Aff. at ¶ 10b.) Geissal stated that he later learned that, by the time Moore informed him that he was not entitled to COBRA coverage, his termination-related claims were time-barred. (Geissal Aff. at ¶ 16.)

Geissal's statements are insufficient to show detrimental reliance. There is no evidence that Geissal accepted the COBRA coverage as part of an express agreement not to take legal action against Moore concerning his termination. Geissal's statements of inchoate claims are speculative and insufficient to withstand summary judgment. Fed. R. Civ. P. 56(e).

Geissal also states that, had he known he would be limited to coverage only through his wife's policy, he would have looked for additional coverage. (Geissal Aff. at ¶ 11.) This statement is speculative at best concerning the outcome of any such search for other coverage, and the statement is insufficient to withstand

summary judgment. *Smith v. Hartford Insurance Group*, 6 F.3d 131, 137 (3d Cir. 1993); Fed. R. Civ. P. 56(e). This is not a case where Geissal found other insurance coverage but decided not to purchase it because of Moore's representation about COBRA continuation coverage. *See National*, 929 F.2d at 1574.

For these reasons, the plaintiff's motion for partial summary judgment will be denied. The material facts are undisputed and defendants are entitled to judgment on Counts I and II as a matter of law. Therefore, judgment will be entered in favor of the defendants on Counts I and II. *Madewell v. Downs*, 68 F.3d 1030. 1048-50 (8th Cir. 1995).

Count III alleges that the defendants, by accepting Geissal's payments, waived any differing construction or interpretation of plan document. Plaintiff did not move for summary judgment on that ground and the parties have not argued it. The doctrines of waiver and estoppel are distinct. *Karlen v. Ray E. Friedman & Co. Commodities*, 688 F.2d 1193, 1197 (8th Cir. 1982). *See Buder v. Fiske*, 174 F.2d 260, 267-68, *reh'g denied*, 177 F.2d 907 (8th Cir. 1949). Plaintiff also did not seek summary judgment on Count IV.

An appropriate order is issued herewith.

/s/ David D. Noce
UNITED STATES
MAGISTRATE JUDGE

Signed this 19th day of March, 1996.

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF MISSOURI
EASTERN DIVISION

No. 4:94 CV 1263 DNN

BONNIE L. GIESSAL,[1]
Plaintiff,

v.

MOORE MEDICAL CORP., et al.,
Defendants.

ORDER

[Filed: March 19, 1996]

In accordance with the Memorandum filed herewith,

IT IS HEREBY ORDERED that plaintiff's motion for partial summary judgment (Doc. No. 20) is denied.

IT IS FURTHER ORDERED that summary judgment is entered for the defendants and against the plaintiff on Counts I and II of the amended complaint. Counts I and II are dismissed.

IT IS FURTHER ORDERED that the parties shall have forty-five days in which to file motions for summary judgment on Counts III and IV.

/s/ David D. Noce
UNITED STATES
MAGISTRATE JUDGE

Signed this 19th day of March, 1996.

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[1] Upon the death of plaintiff James W. Geissal, Bonnie L. Geissal, personal representative of the estate of James W. Geissal, was substituted as party plaintiff. Fed. R. Civ. 25(a).

APPENDIX D

IN THE UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF MISSOURI
EASTERN DIVISION

No. 4:94 CV 263 DDN

BONNIE L. GEISSAL as representative of the
Estate of JAMES W. GEISSAL, deceased, etc.
Plaintiff,

v.

MOORE MEDICAL CORP., et al,
Defendants.

ORDER FOR ENTRY OF FINAL JUDGMENT
COUNTS I AND II

On application of plaintiff and without objection of defendants, the Court hereby determines and finds that by reason of the rationale expressed in the Court's memorandum of March 19, 1996 entered in this matter, entering summary judgment in favor of defendants on the Court's own motion on Counts I and II, the Court hereby expressly determines that is no just reason for delay of entry of final judgment in favor of defendants on Counts I and II. The Court hereby directs the Clerk to enter final judgment in favor of defendants on Counts I and II. In the event plaintiff timely appeals from the entry of such judgments, further action on Counts III and IV shall be stayed until disposition of the appeal.

/s/ David D. Noce
United States Magistrate Judge

Dated at St. Louis, MO
April 4, 1996